THE DIVISION OF HEALTH OF MISSOURI

FILED FEB 12 1951

STANDARD CERTIFICATE OF DEATH

State File No.............

693

BIRTH NO. .... REG. DIST. NO. **99** PRIMARY REG. DIST. NO **5877** Registrar's No. **7**

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY DeKalb			a. STATE MO	b. COUNTY DeKalb
b. CITY OR TOWN Fairport	c. LENGTH OF STAY (in this place) Life		c. CITY OR TOWN Fairport	03
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Mamie	b. (Middle) Elizabeth	c. (Last) Hunt	4. DATE OF DEATH (Month) (Day) (Year) 1-31-51

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-9-1876	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 2 Days 22	IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME James Whitman	13b. MOTHER'S MAIDEN NAME Ollie Porter	14. NAME OF HUSBAND OR WIFE Charles Hunt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Forrest Hunt	ADDRESS Fairport Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Parkinsonian	INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis (General)	
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	4500

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **11-1**, 19**50**, to **1-31**, 19**51**, that I last saw the deceased alive on **1-15**, 19**51**, and that death occurred at **10-a** m., from the causes and on the date stated above.

23a. SIGNATURE James H. Sweeger	(Degree or title) M.D.	23b. ADDRESS Maysville, Mo.	23c. DATE SIGNED 2-6-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-3-51	24c. NAME OF CEMETERY OR CREMATORY Albany	24d. LOCATION (City, town, or county) Albany	(State) Mo

DATE REC'D BY LOCAL REG. 2-6-51	REGISTRAR'S SIGNATURE Roscoe Davidson	25. FUNERAL DIRECTOR'S SIGNATURE John Bram	ADDRESS Maysville Mo

(Licensed Embalmer's Statement on Reverse Side)
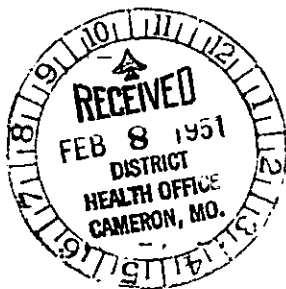
AUG 31 1951

FEB 13 1951

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by...........................

working under my personal supervision.

Student Embalmer No....................................

Signed...........................

Licensed Embalmer No. **3933**

Signed....................................
Student Embalmer

P. O. Address Maysville Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.